U.S. Department of Labor

Office of Administrative Law Judges
John W. McCormack Post Office and Courthouse
Room 505
Boston, MA 02109

(617) 223-9355
(617) 223-4254 (FAX)

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Case Nos.: 2002-LHC-319; 2002-LHC-320

OWCP Nos.: 1-128936; 1-92809

IN THE MATTER OF:

Rheta DeMartino
(Widow of Louis J. DeMartino)
Claimant

Against

Electric Boat Corporation
Employer/Self-Insurer

and

Director, Office of Workers' Compensation Programs
U.S. Department of Labor
Party-in-Interest

APPEARANCES:

Melissa M. Olson, Esq.
For the Claimant

Peter D. Quay, Esq.
For the Employer/Self-Insurer

Merle D. Hyman
Senior Trial Attorney
For the Director

BEFORE: **DAVID W. DI NARDI**
District Chief Judge

DECISION AND ORDER - AWARDING BENEFITS

This is a claim for worker's compensation benefits under the Longshore and Harbor Workers' Compensation Act, as amended (33 U.S.C. §901, **et seq.**), herein referred to as the "Act." The hearing was held on April 17, 2002 in New London, Connecticut, at which time all parties were given the opportunity to present evidence and oral arguments. The following references will be

used: TR for the official hearing transcript, ALJ EX for an exhibit offered by this Administrative Law Judge, CX for a Claimant's exhibit, DX for a Director's exhibit, JX for a Joint exhibit and RX for an exhibit offered by the Employer. This decision is being rendered after having given full consideration to the entire record.

Stipulations and Issues

The parties stipulate, and I find:

1. The Act applies to this proceeding.

2. Decedent and the Employer were in an employee-employer relationship at the relevant times.

3. Claimant alleges that her husband suffered an injury prior to October 12, 1993 in the course and scope of his employment.

4. Claimant gave the Employer notice of the alleged injury in a timely fashion.

5. Claimant filed a timely claim for compensation and the Employer filed a timely notice of controversion.

6. The parties waived the informal conference.

7. The applicable average weekly wage is $1,894.03.

8. The Employer has agreed to pay permanent total compensation from the last day of work through February 3, 1996 and Death Benefits thereafter to the Claimant.

The unresolved issues in this proceeding are:

1. Weekly Compensation Rate for the Death Benefits due Claimant.

2. Entitlement to an award of medical benefits for Decedent's work-related injury.

3. The Employer's entitlement to the limiting provisions of Section 8(f) of the Act has been withdrawn as an issue herein. (JX 1)

Post-hearing evidence has been admitted as:

Exhibit No.	**Item**	**Filing Date**
RX 5A	Attorney Quay's letter filing the	04/19/02

RX 5	October 23, 1987 Consultation Summary Of Dr. Thomas J. Godar (a document Admitted into evidence at the hearing)	04/19/02
RX 6	Attorney Quay's letter to the Regional Solicitor, U.S. Dept. of Labor	04/19/02
RX 7	Attorney Quay's letter filing the June 20, 2002 Deposition Testimony of Dr. Daniel F. Gerardi	07/31/02
JX 1	Parties' Additional Stipulations	08/30/02
CX 6	Attorney Embry's Fee Petition	08/30/02

The record was closed on August 30, 2002 as no further documents were filed.

Summary of the Evidence

Louis J. DeMartino ("Decedent" herein), who was born on July 24, 1931 and who had an employment history of manual labor, testified herein by his April 5, 1990 deposition. (CX 5) Decedent testified that he was an outside machinist from January 2, 1957 at the Groton, Connecticut shipyard of the Electric Boat Company, then a division of the General Dynamics Corporation ("Employer"), a maritime facility adjacent to the navigable waters of the Thames River where the Employer builds, repairs and overhauls submarines. Decedent regularly worked with and was exposed to and inhaled asbestos dust and fibers and other injurious pulmonary stimuli such as welding smoke, grinding dust, paint fumes and he was told by his supervisors that the material with which he worked was asbestos. In November of 1959 Decedent was assigned to the Planning Department and he then worked in a building adjacent to the area where the pipe laggers worked. (CX 5 at 1-22)

Decedent testified that he had no exposure to asbestos while he served in the U.S. Air Force from 1951 to 1955 and that he had no injuries during such service, although he did have surgery at March Air Force Base, Riverside, California, for the removal of cartilage from both knees. (CX 5 at 45-48) Decedent was exposed to asbestos when he worked on board the ship and in the engine store. (CX 5 at 52)

Decedent left the shipyard in 1990, went to work elsewhere for the Employer and stopped working on January 24, 1994. He passed away on February 3, 1996 and Robert J. Keltner, M.D., has certified as the immediate cause of death "bilateral pneumonia" due to or as a consequence of "end stage asbestosis." "Congestive heart failure" and "insulin dependent diabetes" were identified as other significant conditions contributing to death. (CX 1) Decedent married Rheta Claire Ceccarelli ("Claimant") on November 24, 1956

(CX 2) and Claimant was living with Decedent at the time of his death. Funeral expenses exceeded $3,000.00 (CX 3).

Decedent's multiple medical problems are best summarized by the October 23, 1987 Consultation Summary of Dr. Thomas J. Godar, the then Director, Section of Pulmonary Medicine, Saint Francis Hospital and Medical Center, Hartford, Connecticut, wherein the doctor reports as follows (RX 5):

CHIEF COMPLAINT: The patient is a 55 year old white male referred for evaluation of his respiratory status and any possible relationship to previous occupational exposures following previous evaluations by pulmonary physicians with a chief complaint of exercise induced dyspnea in the in the last year considered by the patient to represent a change from his previous status.

OCCUPATIONAL HISTORY:

1950 -	He worked briefly as a heavy equipment operator for the American Construction Company of Hartford, CT.
1950 - 9/55	He served in the United States Air Force as a photography intelligence interpreter and was involved in the production of radar prediction plates for surveillance.
1955 – 1956	He worked for the Mariana Construction Company in New Haven as a heavy equipment operator, working on the construction of a dam and then on the construction of I-95 up to January 1957.
1957 - 1987	The patient worked for the Electric Boat shipyard, division of General Dynamics. He began as an apprentice outside machinist, working with gougers, welders, and others involved in the primary submarine construction which included pipefitters and laggers. He was involved in both new submarine construction and in overhaul and repair activities. In 1959 he moved to the Planning Department and the years 1960 to 1965 he worked next to a room where asbestos mixing was being done and where laggers came and went on a regular basis. He also was exposed to the welders' asbestos blankets and to the work of pipefitters and laggers in the course of his inspection and planning activities. He spent at least 30% of his work time on the submarines although the submarine construction exposure was much diminished in the last 10 years of employment. He was promoted to director of planning and material control, and in the last five years became general supervisor of industrial steel trades. The patient continues to be employed in an office

capacity and has very limited exposure to asbestos since the mid 1970′s. The patient has experienced some shortness of breath on climbing 5 or more flights of stairs, and in October 1986 became extremely short of breath when he ran up more than 5 flights of stairs feeling that perhaps he had developed some respiratory impairment which precipitated further evaluation of his status. The patient was already aware of some chest x—ray abnormalities as early as 1978.

HISTORY OF PRESENT ILLNESS: The patient has known since the 1978 period that he has had an abnormal chest x—ray and recalled having an evaluation at the Lahey Clinic. He has had shortness of breath with vigorous exercise since the 1970's, beginning when he was playing basketball while assigned to a project in Scotland. The patient was informed by Dr. Kent in October 1986 that he had an x—ray abnormality and that this abnormality had been present since approximately 1978, with a pattern suggestive of asbestosis. The patient was referred to Dr. Louis Buckley for evaluation and this was carried out in 1986. He was then referred to Attorney Embry to further pursue his evaluation and possible compensation.

The patient smoked cigarettes from age 19 to age 49 with a consumption between 1 and 1½ packs per day but with an interval between 1935 and 1945 when he discontinued smoking. He stopped entirely at age 49 for a total exposure in the range of 20—30 pack years. He claims that he discontinued smoking for health reasons but did not have significant symptoms at that time.

He denies a history of pulmonary symptoms in the past including cough, sputum production, bronchial asthma, pneumonia, pleurisy, tuberculosis, or chest trauma. However, he does have a history of hay fever associated with exposure to early roses, ragweed, and following an allergic evaluation revealing skin tests reactions to dust and mold was desensitized with injections on a weekly basis for the last 6 or 7 years. In recent years his injections have been administered by his family physician. In addition, he has lost 30 pounds on a diet on the advice of his physician beginning in October 1986.

On admission to the Lawrence and Memorial Hospital on 10/17/83 for an acute cellulitis to the right lower extremity, notes (mention) exogenous obesity and also a history of allergy to penicillin, ragweed, dust, and certain pollens. A chest x—ray was interpreted as revealing chronic obstructive pulmonary disease. The record also notes that in 1983 he was a non—smoker and did not use significant quantities of alcohol.

Pulmonary function tests on 9/25/86 revealed largely normal flow parameters with the exception of peak flow which was only 47% of

predicted but with a flow/volume loop suggestive of suboptimal effort. The PVC was 3.25 liters or 66% of predicted at that time with a height of 71 inches and a weight of 301 pounds. An electrocardiogram revealed only non—specific changes.

On October 1, 1986, the patient was evaluated by Dr. Louis V. Buckley, Chief of Pulmonary Services at Lawrence & Memorial Hospital with the patient presenting with a history of shortness of breath on climbing a hill at the Electric Boat Shipyard and several episodes of shortness of breath on vigorous exertion over the previous 5 years. The patient had not had chest pain and been walking 2 or 3 miles per night for the previous year. He was doing this in part to stabilize his weight. There was a family history of myocardial infarction in his father. He again denied a history of asthma or significant respiratory symptoms in childhood. He denied orthopnea or regular dyspnea on exertion and was able to climb at least 2 flights of stairs. On examination, Dr. Buckley noted bibasilar rales and obesity. The film revealed bilateral pleural disease and probably anterior pleural plaques with some increase in interstitial markings since the films of 1978. Pulmonary function tests on 1/20/86 revealed an PVC of 93% of predicted, a normal FEV_1/FVC ratio, but a moderate reduction in midflow at 63% of predicted while the MVV was 174 liters per minute or 121% of predicted. Total lung capacity was 5.95 or 89% of predicted but the diffusion capacity was 61% of predicted with an oxygen tension of 87 TORR. This study was interpreted as revealing very mild obstructive disease with normal lung volumes but a moderate reduction in diffusion capacity suggesting that exercise testing should be carried out. This was subsequently done revealing to exertion but at good exercise levels with a VO_2 max of 2.5 liters per minute.

The patient was re—evaluated by Dr. Arthur C. DeGraff, Jr. on 2/4/87 with subsequent tests. Dr. DeGraff notes that when working in the production planning office, the patient was physically next to the laggers working area with no separation of air source such that there was dust on his desk and equipment on a regular basis. He further notes that in the shop adjacent to the patient′s office the pre—fabrication work was being carried out and asbestos was being mixed throughout the period that he worked in that area from 1960 to 1966. He reaffirmed the previous history of dyspnea on exertion being first noted in 1975 when the patient was playing basketball. He notes in the history that the patient had had Horton′s headache but that this had resolved. In addition, he notes a 30 pound weight loss since the previous October and his history of penicillin allergy. He estimated that the patient′s smoking at 1½ pack of cigarettes a day for 26 years. On examination he does not note the presence of rales but indicates that the breath sounds had a coarse quality at lung bases. He did note 2+ clubbing of the extremities and mild pretibial edema. A chest film was considered to show pulmonary fibrosis that had first been noted in 1970 and which had progressed since those films. Pulmonary function tests

revealed a continued reduction in diffusion capacity similar to previous studies but the total lung capacity was actually 6.11 liters or 105% of predicted. Residual volume and airway resistance were normal as was airway conductance.

Dr. DeGraff concluded the patient had asbestosis and asbestos related pleural plaques. He felt asbestosis had produced a loss of approximately 50% of the lung transfer surface representing a permanent loss of lung function, his final impression apparently discounting any roll for COPD in reducing diffusion capacity in spite of the extensive cigarette smoking history he documented.

REVIEW OF RECORDS: A review of chest x—ray reports indicates that as early as 8/7/70 chest x—rays were interpreted as revealing pulmonary fibrosis with scarring and possible pleural plaques at the left base. Film of 7/10/75 also revealed pulmonary fibrosis and pleural thickening with special reference to the left pleural space. It was noted that some progression had occurred since the previous examination of 1970. A chest x—ray reading on 9/25/86 and 1/19/87 suggests extensive bilateral pulmonary interstitial fibrosis which had progressed from films of 1975 and 1978...

LABORATORY STUDIES:

Pulmonary Function Tests - Pulmonary function studies on 5/21/87 reveal normal lung volumes with total lung capacity 91% of predicted in spite of obesity. The effects of obesity are reflected in a moderate reduction in ERV. Gas mixing is normal and the maximum voluntary ventilation is well-preserved. Blood gas analysis reveals no evidence for hypoxemia at rest and indeed the A—a 0-2 difference is 6.5 mmHg. The diffusion capacity is moderately reduced by both steady state and single breath methods. The study suggests no significant restrictive component except for a marginal change which is secondary to obesity. Some abnormality in small airway parameters which are largely limited to midflow and terminal flow show some response to bronchodilator consistent with a low grade bronchitis. A well preserved MVV and normal gas mixing suggest that pulmonary emphysema is not a significant component though very early disease may be present.

Chest X-Rays Chest films between 1973 and 1987 reveal evidence of bilateral pleural thickening with pleural plaques consistent with those seen in asbestos exposure. In addition, there is significant diffuse pulmonary fibrosis more concentrated in mid and lower lung fields present in 1970 and gradually

progressing to the film of 1987, at which time fibrotic disease is well demarcated and quite prominent. There is some obscurity of diaphragm border and cardiac border in a pattern quite consistent with asbestosis.

IMPRESSIONS: Bilateral pleural thickening with plaques consistent with asbestos exposure, without significant impairment affect. Moderate bilateral pulmonary fibrosis consistent with asbestosis with evidence of diffusion defect but no evidence of hypoxemia or significant lung volume loss, associated with mild dyspnea on vigorous exercise.

Obesity, exogenous, moderate.

Probable early COPD secondary to extensive cigarette smoking with obstructive airway disease obscured by increased elastic recoil associated with diffuse asbestosis.

The patient's history of exposure and the classical x—rays are quite consistent with pulmonary asbestosis. Unlike early examination when bibasilar rales were noted by Dr. Buckley and the absence of rales noted by Dr. DeGraff, I find persistent crepitent rales that are typical for interstitial fibrosis at the right base posteriorly but am unable to document the presence of rales at the left base as one would anticipate. It may well be that sounds are obscured by significant obesity. At any rate, the pattern is quite consistent with pulmonary asbestosis and that is consistent with a history of significant exposure. I believe the patient has a small degree of airway disease which is partly obscured by asbestosis as a consequence of very extensive cigarette smoking but it is clear that anything except early emphysema is not present since the maximum voluntary ventilation is well preserved and gas mixing is quite normal. It is therefore possible to say that the patient may have a mild restrictive abnormality in that lung volumes are low—normal in the presence of some obstructive airway disease. However, the obesity manifested by this patient is sufficient to cause a mild restrictive defect in itself.

The findings are an unusual combination and his function is considerably better than I would anticipate based on his smoking history and the x—ray abnormality. It is also striking that there is no hypoxemia at rest and in fact he has a low— normal A—a 0-2 difference in spite of diffuse pulmonary fibrosis.

Based on the above examination, and given some discrepancy in findings, the patient does have a permanent limitation of lung function and this is a loss of 25% of lung function for both lungs and for the whole person based on the AMA Respiratory Impairment Guidelines. This estimate of lung function loss is based on the

absence of hypoxemia or abnormal lung volumes, the presence of only a mild element of airway obstruction manifested by abnormal small airway flow parameters, and a loss in diffusion capacity that is only mild to moderate as the single most sensitive and definitive evidence of functional loss. Only a minimal portion of that functional loss can be ascribed to airway disease and it is difficult to establish any specific duty specific percentage of that loss that could be ascribed to airway disease that probably is in the order of the total functional loss. The patient appears to handle obesity relatively well but no doubt that is a factor causing dyspnea on moderate exercise.

I believe the permanent limitation of function is causally related to his employment at Electric Boat Shipyard in that it appears to be largely due to asbestosis and it is true that his continued employment after his abnormal chest x—ray of August 1970 probably has contributed to a more permanent and significant limitation of function which is materially and substantially greater than if he had not had further exposure following the 1970 abnormality, according to the doctor.

Decedent was examined by Arthur C. DeGraff, Jr., M.D., a pulmonary specialist, on November 16, 1993 and the doctor reports as follows in his report. (CX 4-2 and 3)

Thank you for asking me to reevaluate Louis DeMartino. I saw him for reevaluation on 11/16. Mr. DeMartino has experienced progressive increase in shortness of breath over the past four years. He had a bout of “pneumonia” eight months ago. He has never been placed on steroids. He has lost 10 pounds. Despite his progressive increase in shortness of breath, he continues to work. He notes marked increase in shortness of breath on climbing stairs. With exercise he senses the need to urinate which may be an indication of hypoxia consequent to the exercise. He recently worked in East Windsor decommissioning a nuclear plant. He continues to have cough in the morning.

On physical examination blood pressure is 120/80. Lungs show bilateral inspiratory crackles. Heart sounds are normal. There is no organomegaly present. There is 2+ pretibial edema present.

Spirometry revealed reduced forced vital capacity as compared to prior study, with forced vital capacity now being 2.8 liters. Shortly before I saw him, in the pulmonary laboratory forced vital capacity was 3.5 liters. This change is likely the consequence of fatigue. Forced vital capacity in my office on 2/4/87 was 4.3 liters. Diffusing capacity measurements are compared, on 2/10/87 the apparent diffusing capacity was 16.8. On 6/12/89 apparent diffusing capacity was 11.9. on 11/16/93 diffusing capacity is 7.3. Similar changes are noted in calculated membrane diffusing capacity, on 2/10/87 membrane diffusing capacity was 34. on 6/12/89 membrane diffusing capacity was 18. On 11/16/93 membrane diffusing

capacity is 9. In terms of percent predicted, the membrane diffusing capacity is now 18% of predicted and apparent diffusing capacity is 26% of predicted. This fall in diffusing capacity is accompanied by arterial hypoxia with exercise. With exercise, oxygen saturation falls to a minimum of 79% as would be predicted on the basis of impaired diffusion.

Mr. DeMartino's chest x-ray was reviewed. There is increased infiltrate and the infiltrate is "harder" as compared to prior x-ray, consistent with progressive scarring of lungs.

COMMENT: Mr. DeMartino is clearly severely disabled as a consequence of his progressive asbestosis. Because of severe loss of lung function, he is no longer able to function without supplemental oxygen. He is now totally disabled with severe impairment of the whole person which I would rate as 80% impairment of the whole person according to AMA **Guidelines for Disability Evaluation**. His disease is clearly progressive and at the rate it is progressing, I would estimate that for his continued survival, he will require a lung transplant within the next two years, according to the doctor who then issued the following supplemental report on January 13, 1994 (CX 4):

In answer to your letter of 12/30/93 concerning Mr. DeMartino, I believe that our letters probably crossed. You should have received a letter from me dated 12/9 in which I indicate that Mr. DeMartino's disease has progressed to the point where he is now 80% disabled according to AMA **Guidelines for Disability Evaluation**. It is my opinion that he is totally disabled and should no longer work.

Dr. Godar re-examined Decedent on March 7, 1994 and the doctor issued the following Consultation Summary (RX 4):

CHIEF COMPLAINT: The patient is a 62 year old white male employed at the Electric Boat Shipyard from 1957 to the present time, primarily in a supervisory capacity in the last 12 years and operating the Windsor site for the Electric Boat Shipyard in the period 1990 to the present time, the patient having been relocated to the office site in the New London plant for proximity to his treating physicians and often working 4 hours a day since an admission to the hospital in early 1993 for pneumonia. Beginning on 03/11/94 the patient was placed on a 26 week medical leave of absence to begin on 03/11/94 and to continue to the point of retirement. For the period May, June, and July 1993 he was only permitted to work a half day following treatment for pneumonia under the direction of Dr. Donald Kent, the Electric Boat Shipyard Medical Director.

This patient was initially seen in consultation at the request of National Employers Company on 05/21/87 and the subsequent report is on file and available for review. The patient presented as a 55

year old white male who had had exercise associated dyspnea for one year and who had been evaluated by pulmonary physicians who reached the conclusion that he had asbestosis that required follow-up for possible progression.

His occupational history was significant for the operation of heavy equipment and work in construction except for 5 years in the United States Air Force when he worked as a photography intelligence interpreter between 1950 and 1955, his heavy construction beginning in 1950 and continuing through January 1957. Thereafter he worked for the Electric Boat Shipyard as an apprentice outside machinist and subsequently as an outside machinist which provided him with substantial exposure to pipefitters, laggers, and other construction trades in which there was substantial asbestos exposure. In the period 1959 to 1965 he was in the Planning Department but he worked in a room next to where asbestos was being mixed and in the area through which laggers came and went on a regular basis. In the morning he often swept dust off the equipment before he was able to work and he later learned that this was largely asbestos dust. He spent about 1/3 of his time on the submarines but in the period 1977 through 1987 had much less exposure to the submarine environment. In approximately 1982 he was promoted to director of planning and material control and largely supervised industrial steel trades. Throughout the l970s he worked primarily in the office and had little exposure to asbestos, but by 1986 was experiencing shortness of breath on exertion that precipitated further evaluation. He was aware of some chest x—ray abnormalities as early as 1978. In 1986 he was informed by Dr. Donald Kent that he had an x-ray abnormality and that this had been present since approximately 1978 with a pattern suggestive of asbestosis. The patient gave a history of smoking from age 19 to age 49 with a consumption between 1 and 1½ packs per day, but there was a long interval of years when he discontinued smoking. He stopped smoking at age 49 and I estimated his total exposure to be a 20—30 pack year exposure. He gave a history of hayfever associated with exposure to roses and ragweed and following an allergic evaluation, had positive skin tests to dust and mold with subsequent desensitization on a weekly basis that persisted for some 6-7 years. He also had a history of allergy to penicillin when a cellulitis of the right lower extremity was being treated. In 1983 his chest film was considered consistent with COPD. His peak flows were abnormal and his forced vital capacity was 3.25 liters or 66% of predicted, although his height was 71 inches and his weight on pulmonary function tests was 301 lbs. He was seen in 1986 for some shortness of breath on climbing the hill to the parking lot and had noted some shortness of breath with vigorous exercise over the previous 5 years. His x—ray revealed pleural plaques with some increase in interstitial markings that had occurred since the original films of 1978. His diffusion capacity was 61% of predicted but his maximum voluntary ventilation was 174 liters per minute and well above predicted. The patient was reevaluated by Dr. Arthur C.

DeGraff, Jr. on 02/04/87 at which time his total lung capacity was 6.11 liters or 105% of predicted with a normal residual volume and airway resistance but a reduced diffusion capacity. He concluded the patient had asbestosis and pleural plaques associated with asbestos exposure. He considered the patient had a loss of approximately 50% of his lung transfer surface but did not include COPD in his list of causes for impaired diffusion. Old medical records had revealed that as early as 08/07/70 chest films had revealed pulmonary fibrosis with possible pleural plaques at the left base. He had developed extensive bilateral pulmonary interstitial fibrosis between 1970 and the films of 1987. He had also been treated with a diuretic for ankle edema as early as 1986. He had been substantially obese following discontinuing smoking and this was one reason he resumed smoking at age 45. On examination in 1987 he had crepitant rales at the right base posteriorly but no findings at the left base. He was obese and the extremities did reveal mild pitting edema of the ankles and pretibial areas. Pulmonary function testing on 05/21/87 revealed normal lung volumes with a total lung capacity of 6.10 liters or 91% of predicted in the face of obesity with evidence of mild hyperventilation and a high normal oxygen tension. There was a moderate reduction in diffusion capacity but flow abnormalities were minimal and limited to small airway flow reductions. His chest films were considered consistent with asbestosis and pleural plaques. It was considered he had bilateral pleural thickening with plaque formation that was consistent with asbestos exposure but without producing significant impairment. In addition, he had a moderate bilateral pulmonary fibrosis which was more striking on the right lung and which was consistent with asbestosis. He also had COPD due to cigarette smoking and exogenous obesity. The report of 1987 noted that bilateral rales had been heard by Dr. Buckley and rales had not been heard by Dr. DeGraff in his examination, whereas my examination revealed crepitant rales on the right posterior base but none on the left. Since his oxygen tension was normal and his maximum voluntary ventilation was well preserved with relatively rapid gas mixing, it seemed unlikely that he had significant emphysema although he did appear to have an element of obstructive airway disease. The long term nature of the fibrosis was suggested by an intact oxygen tension and appeared quite consistent with asbestosis. Although functional impairment was probably contributed to by obesity and COPD, the asbestosis was considered the predominant abnormality.

INTERVAL HISTORY: In the early l990s he underwent a right hip replacement at Lawrence and Memorial Hospital.

On 02/04/93 he was referred to Dr. Robert Keltner by Dr. Steven Johnson because of pneumonia. He had been stable until several weeks previously when he had had symptoms of an upper respiratory infection with rhinitis and purulent secretions. A chest film revealed pneumonia involving the right upper lung field superimposed on chronic interstitial fibrosis and pleural

thickening. The patient was placed on an antibiotic. His medical records indicate he was given an award for asbestosis and that he was increasingly aware of shortness of breath on climbing stairs although he had been relatively stable until his recent infection. The patient had noted that finger clubbing had been present for some time and his nail beds were frequently gray in color. There was no history for cardiac failure or hypertension and he had no history for angina pectoris, myocardial infarction or arrhythmia. The medical record documents that the patient did smoke 2-3 packs per day while a cigarette smoker but that he had stopped smoking entirely some 16 or 17 years previously. He had had frequent respiratory tract infections and he had a history of a total right hip replacement for osteoarthritis in 1990 and surgery on both knees for torn cartilage. He was on no medications and gave a history of allergy to penicillin. He was described as chronically overweight and had lost some 10 lbs over the previous year with some efforts to reduce his weight. Chest film were carefully reviewed with previous films and there was in fact an acute infiltrate in the right upper lung field which was patchy and raised the question of a pneumonia superimposed on a lung in which there were some lucent spaces that might represent bullae. He was treated with antibiotics and bronchodilators and because of persistent chest discomfort, chills, sweats, and some dizziness associated with cough, he was urged to accept hospitalization on 02/08/93 and subsequently was admitted to the Lawrence and Memorial Hospital with a bacterial pneumonia. His x-rays did in fact improve with antibiotic treatment and the use of bronchodilators consistent with a recently acquired pneumonia superimposed on pulmonary fibrosis. His discharge diagnosis also included chronic obstructive pulmonary disease. He underwent bronchoscopy and a thorough evaluation to rule out a hidden malignancy. Additionally noted were exogenous obesity and degenerative joint disease with a right total hip replacement and bilateral arthroscopic knee procedures. His evaluation revealed no evidence for a malignancy and there was improvement in his right upper lobe pneumonitis by chest x—ray consistent with a slowly clearing bacterial pneumonia superimposed on fibrosis. On 03/01/93 the patient was able to discontinue all medications. The patient underwent a bronchoscopic evaluation to rule out an endobronchial lesion by Dr. John Urbanetti on 03/02/93 and this failed to reveal evidence for an endobronchial lesion. He had some side—effects from bronchodilator therapy, especially feeling shaky and dizzy, this previously ascribed to the use of theophylline in conjunction with Cipro. On 03/24/93 he was considered clear to return to work on a ½ day basis to begin on the 29th on March with possibly a resumption of full-time employment 2 weeks later.

In an office note of 04/14/93 Dr. Urbanetti notes that the patient was complaining of increasing dyspnea such that he was limited to 1 flight of stairs. He had a trace of peripheral edema. The patient states that he was removed from the Windsor, Ct, Electric Boat Reactor Site and returned to the Electric Boat Shipyard in Groton

to permit proximity to his treating physicians. More recently it was concluded that the patient should enter into a 26 week medical leave of absence to begin on 03/11/94 at which time he probably should retire although a final decision would be made at that time.

On 12/09/93 the patient's re-evaluation by Dr. Arthur C. DeGraff, Jr., is summarized. The record notes his episode with pneumonia and his increasing dyspnea on exertion over the previous 4 years. On examination he had bilateral inspiratory crackles and he had 2+ pretibial edema. His forced vital capacity which had been 4.3 liters in 1987 was now 3.47 liters and small airway flow was 38% with an FEV_1/FVC ratio of 67%. In the meantime his diffusion capacity which had been 16.8 on 02/10/87 had dropped to 11.9 on 06/12/89 and was now 7.3 in conjunction with hypoxemia that progressed with exercise such that with minimal exercise the patient desaturated to 79%. His chest film was considered consistent with some increase in fibrosis. He was considered severely disabled as a consequence of progressive asbestosis and concluded that he could no longer function without supplemental oxygen. He was therefore considered totally disabled with an impairment of 80% of the whole person using the AMA **Guidelines for Disability Evaluation**. It was concluded that for continued survival he would probably require a lung transplant within 2 years. Although it was concluded that he had a mixture of obstructive and restrictive disease, no comment was made with regard to the extent to which his substantial weight might be contributing to the restrictive component.

At the present time the patient is able to walk 1-2 blocks, can climb ½ flight of stairs on the best days but usually stops every second or third step. He uses 2 pillows in the evening but does not experience orthopnea or paroxysmal nocturnal dyspnea. He has a cough that occurs primarily in the morning on arising and frequently in the late evening. His medications consisted of Proventil aerosol and Atrovent, both discontinued because he complained of shaking and dizziness. He has never been found to be hypertensive in spite of obesity and is currently receiving no medications except for 2 liters per minute of supplemental oxygen by nasal cannula for a minimum of 18 hours a day. He does note that he has lost 34 lbs in the last year and therefore apparently at some point exceeded 300 lbs. He denies wheeze and has not been hospitalized since February 1993. He received the pneumovax and the flu vaccine in late 1993. He was out of work 3 weeks with a bronchitis under treatment by Dr. Keltner in January of 1994.

The patient indicates that he has not considered himself disabled enough for retirement since last summer after his pneumonia he was able to accommodate by using a special parking area permitted him with an elevator so that he could readily reach the office area in the Design Department. It appears that his treating physicians concluded that he should have a half year off from work for stabilization following which it would be decided if he should

apply for long term disability or simply take outright retirement based on the relative financial merits of either.

Pulmonary Function Tests - Pulmonary function studies on 03/07/94, a copy enclosed, reveals airway obstruction that is mild in degree and bordering on moderate but partly exaggerated by a combined restrictive defect. There is no consistent response to bronchodilator although small airway flow appears to improve after bronchodilator. The maximum voluntary ventilation is mildly reduced and 76% of predicted after bronchodilator. There is mild distention but the ERV is moderately reduced and the TLC is mildly reduced at 78% of predicted, in part consistent with obesity. The diffusion capacity is severely reduced at 8.11 or 25% of predicted. Resting oxygen tension with the patient on ambient air is 92% suggesting mild hypoxemia and at 21 pm the saturation rose to 96% at rest. The findings are consistent with mixed obstructive and restrictive disease with the restriction at least in part secondary to obesity. The most significant finding is a severe loss in diffusion capacity compared to earlier studies.

Chest X-Rays - A chest film performed at the Jefferson X-Ray Group on 06/07/89 reveals similar findings of bilateral diffuse pulmonary fibrosis most concentrated in the lower lung field in conjunction with pleural thickening and plaque formation, all quite consistent with moderate pleural disease and pulmonary asbestosis. The findings are similar to those of the 1987 study. Subsequent films of 11/16/93 reveal the same pattern, the lateral film does reveal an increase in AP diameter and some flattening of the hemidiaphragms consistent with COPD. The most recent film of 03/07/94 reveals similar findings consistent with diffuse bilateral asbestosis and pleural thickening with plaque formation and with the fibrosis concentrated in the lower lung fields, especially in the right lung compared to the left. The presence of some lucent areas in the right upper lung fields and in the left upper lobe is consistent with an associated COPD.

CT scans of the chest on 12/06/89 performed by the Jefferson X-Ray Group are available for review. These reveal significant upper lobe lucency consistent with bullae and COPD with bilateral pleural plaques, pleural thickening, and findings consistent with pulmonary fibrosis, especially involving the periphery of the lung and especially the lower lung fields. The findings are consistent with asbestosis although non—specific.

IMPRESSIONS: 1)Bilateral pleural thickening with plaque formation consistent with remote asbestos exposure.

2)Moderate bilateral pulmonary fibrosis consistent with asbestosis associated with both a severe diffusion defect and hypoxemia responding to supplemental oxygen.

3)Rule out cor pulmonale with early right heart failure.

4)COPD associated with cigarette smoking, partly masked by the restrictive defect with increased elastic recoil.

5)Obesity, exogenous, moderate.

COMMENTS AND RECOMMENDATIONS: To begin with Mr. DeMartino certainly has demonstrated his interest in gainful employment by working under somewhat difficult circumstances and eagerly cooperating with a return to the workplace while using supplemental oxygen although Dr. Kent was not enthusiastic about this condition of his employment following his recovery from the pneumonia in early 1993. It is my belief the patient's obesity is contributing to the restrictive defect and is certainly increasing the work of breathing and contributing to his dyspnea. I also believe it is quite clear that the patient does have COPD although it is mild, and since his diffusion capacity was only mildly impaired in 1987, it is likely that having discontinued smoking some time ago, the patient's continued reduction in diffusion capacity since 1987 is likely the result of progression of pulmonary asbestosis. I do not believe there is any question about the patient having extensive bilateral pulmonary asbestosis as a significant contributor to his impairment while I believe the pleural plaques and bilateral pleural thickening are a minimal contributor if at all. Based on our findings on examination on 03/07/94 the patient does have mixed restrictive disease due to obesity and asbestosis combined with obstructive disease due to COPD and secondary to his previous cigarette smoking. His diffusion defect is his limiting impairment and it is my opinion that will not improve, rather it will likely slowly progress. He has done well on supplemental oxygen but it does not seem likely that he will be able to eliminate supplemental oxygen at any time in the future and if the reduction in diffusion capacity continues at its current rate he certainly would have a relatively limited prognosis and might well indeed be a candidate for lung transplant in the next 2-5 years. On the other hand, if he loses substantial weight he will reduce oxygen requirements and improve lung function including the restrictive component and therefore may do better longer. I should make it clear that obesity does not affect the diffusion capacity and that his diffusion defect is indeed severe and progressing. With regard to the patient's pleural thickening, plaques and moderate bilateral pulmonary fibrosis consistent with asbestosis, I think there is a distinct causal relationship between his employment at the Electric Boat Shipyard and his asbestosis. Using the AMA **Respiratory Impairment Guidelines**, and based primarily on his most significant defect, that of the reduced diffusion capacity, the patient has a 60% impairment of function for both lungs and the whole man based on asbestosis, some restriction associated with obesity, and airway obstruction due to COPD secondary to cigarette smoking. I believe

the majority of his impairment is due to asbestosis, or approximately 45% impairment, the remainder being due to COPD and obesity, probably about equally.

Since the patient's cigarette smoking occurred at a relatively early age and his obstructive airway disease therefore began well before the development of asbestosis, he did have COPD as a pre-existing condition as well as long term obesity which both played a role in leading to his present disability and rendering his present disability materially and substantially greater than it would have been had he had the asbestosis alone. Furthermore, his present disability is in good measure due to asbestosis but under no circumstances is it due entirely to asbestosis. That is, the asbestosis is not the sole basis for his current disability.

Based on the risk of right heart failure and of increased hypoxemia induced by physical activity in spite of what appears to be well controlled oxygen treatment, I do agree that the risk of continued employment exceeds the benefits of the overall activity physically and psychologically, and therefore I believe that it is in his best interest in terms of survival and stability to discontinue active employment at the end of the planned medical leave of absence period of 26 weeks.

It should be made clear that a major goal for the patient should be the loss of a minimum of 70—80 lbs to reduce cardiovascular stress, to reduce the dyspnea associated with obesity and the increased work of breathing, and to improve lung volume measurements. Although the patient indicates he did improve with the use of bronchodilator medication, the repeated occurrence of dizziness, and "shakes" forced him to discontinue bronchodilators such that he is currently on no medication. A resumption of bronchodilator therapy with a cautious dose and gradual progression might well produce some improvement but pulmonary function tests have failed to reveal any significant improvement aside from improved small airway flow following the bronchodilator. I consider that that is not a sufficient improvement to warrant running the risks of side effects and therefore it is likely the patient will return to not using bronchodilator drugs, according to the doctor.

On the basis of the totality of this record and having observed the demeanor and heard the testimony of a credible Claimant, I make the following:

Findings of Fact and Conclusions of Law

This Administrative Law Judge, in arriving at a decision in this matter, is entitled to determine the credibility of the witnesses, to weigh the evidence and draw his own inferences from it, and he is not bound to accept the opinion or theory of any particular medical examiner. **Banks v. Chicago Grain Trimmers**

Association, Inc., 390 U.S. 459 (1968), **reh. denied**, 391 U.S. 929 (1969); **Todd Shipyards v. Donovan**, 300 F.2d 741 (5th Cir. 1962); **Scott v. Tug Mate, Incorporated**, 22 BRBS 164, 165, 167 (1989); **Hite v. Dresser Guiberson Pumping**, 22 BRBS 87, 91 (1989); **Anderson v. Todd Shipyard Corp.**, 22 BRBS 20, 22 (1989); **Hughes v. Bethlehem Steel Corp.**, 17 BRBS 153 (1985); **Seaman v. Jacksonville Shipyard, Inc.**, 14 BRBS 148.9 (1981); **Brandt v. Avondale Shipyards, Inc.**, 8 BRBS 698 (1978); **Sargent v. Matson Terminal, Inc.**, 8 BRBS 564 (1978).

The Act provides a presumption that a claim comes within its provisions. **See** 33 U.S.C. §920(a). This Section 20 presumption "applies as much to the nexus between an employee's malady and his employment activities as it does to any other aspect of a claim." **Swinton v. J. Frank Kelly, Inc.**, 554 F.2d 1075 (D.C. Cir. 1976), **cert. denied**, 429 U.S. 820 (1976). Claimant's uncontradicted credible testimony alone may constitute sufficient proof of physical injury. **Golden v. Eller & Co.**, 8 BRBS 846 (1978), **aff'd**, 620 F.2d 71 (5th Cir. 1980); **Hampton v. Bethlehem Steel Corp.**, 24 BRBS 141 (1990); **Anderson v. Todd Shipyards**, **supra**, at 21; **Miranda v. Excavation Construction, Inc.**, 13 BRBS 882 (1981).

However, this statutory presumption does not dispense with the requirement that a claim of injury must be made in the first instance, nor is it a substitute for the testimony necessary to establish a "**prima facie**" case. The Supreme Court has held that "[a] **prima facie** 'claim for compensation,' to which the statutory presumption refers, must at least allege an injury that arose in the course of employment as well as out of employment." **United States Indus./Fed. Sheet Metal, Inc., v. Director, Office of Workers' Compensation Programs, U.S. Dep't of Labor**, 455 U.S. 608, 615 102 S. Ct. 1318, 14 BRBS 631, 633 (CRT) (1982), **rev'g Riley v. U.S. Indus./Fed. Sheet Metal, Inc.**, 627 F.2d 455 (D.C. Cir. 1980). Moreover, "the mere existence of a physical impairment is plainly insufficient to shift the burden of proof to the employer." **U.S. Industries/Federal Sheet Metal, Inc., et al., v. Director, Office of Workers' Compensation Programs, U.S. Department of Labor**, 455 U.S. 608, 102 S.Ct. 1318 (1982), **rev'g Riley v. U.S. Industries/Federal Sheet Metal, Inc.**, 627 F.2d 455 (D.C. Cir. 1980). The presumption, though, is applicable once claimant establishes that he has sustained an injury, **i.e.**, harm to his body. **Preziosi v. Controlled Industries**, 22 BRBS 468, 470 (1989); **Brown v. Pacific Dry Dock Industries**, 22 BRBS 284, 285 (1989); **Trask v. Lockheed Shipbuilding and Construction Company**, 17 BRBS 56, 59 (1985); **Kelaita v. Triple A. Machine Shop**, 13 BRBS 326 (1981).

To establish a **prima facie** claim for compensation, a claimant need not affirmatively establish a connection between work and harm. Rather, a claimant has the burden of establishing only that

(1) the claimant sustained physical harm or pain and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused the harm or pain. **Kelaita**, **supra**; **Kier v. Bethlehem Steel Corp.**, 16 BRBS 128 (1984). Once this **prima facie** case is established, a presumption is created under Section 20(a) that the employee's injury or death arose out of employment. To rebut the presumption, the party opposing entitlement must present substantial evidence proving the absence of or severing the connection between such harm and employment or working conditions. **Kier**, **supra**; **Parsons Corp. of California v. Director, OWCP**, 619 F.2d 38 (9th Cir. 1980); **Butler v. District Parking Management Co.**, 363 F.2d 682 (D.C. Cir. 1966); **Ranks v. Bath Iron Works Corp.**, 22 BRBS 301, 305 (1989). Once claimant establishes a physical harm and working conditions which could have caused or aggravated the harm or pain the burden shifts to the employer to establish that claimant's condition was not caused or aggravated by his employment. **Brown v. Pacific Dry Dock**, 22 BRBS 284 (1989); **Rajotte v. General Dynamics Corp.**, 18 BRBS 85 (1986). If the presumption is rebutted, it no longer controls and the record as a whole must be evaluated to determine the issue of causation. **Del Vecchio v. Bowers**, 296 U.S. 280 (1935); **Volpe v. Northeast Marine Terminals**, 671 F.2d 697 (2d Cir. 1981). In such cases, I must weigh all of the evidence relevant to the causation issue. **Sprague v. Director, OWCP**, 688 F.2d 862 (1st Cir. 1982); **MacDonald v. Trailer Marine Transport Corp.**, 18 BRBS 259 (1986).

In the case **sub judice**, Claimant alleges that the harm to her husband's bodily frame, **i.e.**, his asbestosis and his chronic obstructive pulmonary disease (COPD), resulted from working conditions or resulted from his exposure to and inhalation of asbestos at the Employer's shipyard. The Employer has introduced no evidence severing the connection between such harm and Claimant's maritime employment. In this regard, **see Romeike v. Kaiser Shipyards**, 22 BRBS 57 (1989). Thus, Claimant has established a **prima facie** claim that such harm is a work-related injury, as shall now be discussed.

Injury

The term "injury" means accidental injury or death arising out of and in the course of employment, and such occupational disease or infection as arises naturally out of such employment or as naturally or unavoidably results from such accidental injury. **See** 33 U.S.C. §902(2); **U.S. Industries/Federal Sheet Metal, Inc., et al., v. Director, Office of Workers Compensation Programs, U.S. Department of Labor**, 455 U.S. 608, 102 S.Ct. 1312 (1982), **rev'g Riley v. U.S. Industries/Federal Sheet Metal, Inc.**, 627 F.2d 455 (D.C. Cir. 1980). A work-related aggravation of a pre-existing condition is an injury pursuant to Section 2(2) of the Act. **Gardner v. Bath Iron Works Corporation**, 11 BRBS 556 (1979), **aff'd**

sub nom. Gardner v. Director, OWCP, 640 F.2d 1385 (1st Cir. 1981); **Preziosi v. Controlled Industries**, 22 BRBS 468 (1989); **Janusziewicz v. Sun Shipbuilding and Dry Dock Company**, 22 BRBS 376 (1989) (**Decision and Order on Remand**); **Johnson v. Ingalls Shipbuilding**, 22 BRBS 160 (1989); **Madrid v. Coast Marine Construction**, 22 BRBS 148 (1989). Moreover, the employment-related injury need not be the sole cause, or primary factor, in a disability for compensation purposes. Rather, if an employment-related injury contributes to, combines with or aggravates a pre-existing disease or underlying condition, the entire resultant disability is compensable. **Strachan Shipping v. Nash**, 782 F.2d 513 (5th Cir. 1986); **Independent Stevedore Co. v. O'Leary**, 357 F.2d 812 (9th Cir. 1966); **Kooley v. Marine Industries Northwest**, 22 BRBS 142 (1989); **Mijangos v. Avondale Shipyards, Inc.**, 19 BRBS 15 (1986); **Rajotte v. General Dynamics Corp.**, 18 BRBS 85 (1986). Also, when claimant sustains an injury at work which is followed by the occurrence of a subsequent injury or aggravation outside work, employer is liable for the entire disability if that subsequent injury is the natural and unavoidable consequence or result of the initial work injury. **Bludworth Shipyard, Inc. v. Lira**, 700 F.2d 1046 (5th Cir. 1983); **Mijangos**, **supra**; **Hicks v. Pacific Marine & Supply Co.**, 14 BRBS 549 (1981). The term injury includes the aggravation of a pre-existing non-work-related condition or the combination of work- and non-work-related conditions. **Lopez v. Southern Stevedores**, 23 BRBS 295 (1990); **Care v. WMATA**, 21 BRBS 248 (1988).

In occupational disease cases, there is no "injury" until the accumulated effects of the harmful substance manifest themselves and claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease and the death or disability. **Travelers Insurance Co. v. Cardillo**, 225 F.2d 137 (2d Cir. 1955), **cert. denied**, 350 U.S. 913 (1955). **Thorud v. Brady-Hamilton Stevedore Company, et al.**, 18 BRBS 232 (1987); **Geisler v. Columbia Asbestos, Inc.**, 14 BRBS 794 (1981). Nor does the Act require that the injury be traceable to a definite time. The fact that claimant's injury occurred gradually over a period of time as a result of continuing exposure to conditions of employment is no bar to a finding of an injury within the meaning of the Act. **Bath Iron Works Corp. v. White**, 584 F.2d 569 (1st Cir. 1978).

This closed record conclusively establishes, and I so find and conclude, that Decedent's daily exposure to and inhalation of asbestos dust and fibers and other injurious stimuli has resulted in medical conditions diagnosed as asbestosis and COPD, that the date of injury is prior to October 12, 1993, that the Employer had timely notice of such conditions, that the Employer timely controverted Decedent's entitlement to benefits once a dispute arose between the parties. In fact, the principal issue is the nature and extent of Decedent's disability, an issue I shall now

resolve.

Average Weekly Wage

For the purposes of Section 10 and the determination of the employee's average weekly wage with respect to a claim for compensation for death or disability due to an occupational disability, the time of injury is the date on which the employee or claimant becomes aware, or on the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability. **Todd Shipyards Corp. v. Black**, 717 F.2d 1280 (9th Cir. 1983); **Hoey v. General Dynamics Corporation**, 17 BRBS 229 (1985); **Pitts v. Bethlehem Steel Corp.**, 17 BRBS 17 (1985); **Yalowchuck v. General Dynamics Corp.**, 17 BRBS 13 (1985).

The Act provides three methods for computing claimant's average weekly wage. The first method, found in Section 10(a) of the Act, applies to an employee who shall have worked in the employment in which he was working at the time of the injury, whether for the same or another employer, during **substantially** the whole of the year immediately preceding his injury. **Mulcare v. E.C. Ernst, Inc.**, 18 BRBS 158 (1987). "Substantially the whole of the year" refers to the nature of Claimant's employment, **i.e.**, whether it is intermittent or permanent, **Eleazar v. General Dynamics Corporation**, 7 BRBS 75 (1977), and presupposes that he could have actually earned wages during all 260 days of that year, **O'Connor v. Jeffboat, Inc.**, 8 BRBS 290, 292 (1978), and that he was not prevented from so working by weather conditions or by the employer's varying daily needs. **Lozupone v. Stephano Lozupone and Sons**, 12 BRBS 148, 156 and 157 (1979). A substantial part of the year may be composed of work for two different employers where the skills used in the two jobs are highly comparable. **Hole v. Miami Shipyards Corp.**, 12 BRBS 38 (1980), **rev'd and remanded on other grounds**, 640 F.2d 769 (5th Cir. 1981). The Board has held that since Section 10(a) aims at a theoretical approximation of what a claimant could ideally have been expected to earn, time lost due to strikes, personal business, illness or other reasons is not deducted from the computation. **See O'Connor v. Jeffboat, Inc.**, 8 BRBS 290 (1978). **See also Brien v. Precision Valve/Bayley Marine**, 23 BRBS 207 (1990); **Klubnikin v. Crescent Wharf & Warehouse Co.**, 16 BRBS 183 (1984). Moreover, since average weekly wage includes vacation pay in lieu of vacation, it is apparent that time taken for vacation is considered as part of an employee's time of employment. **See Waters v. Farmer's Export Co.**, 14 BRBS 102 (1981), **aff'd per curiam**, 710 F.2d 836 (5th Cir. 1983), **Duncan v. Washington Metropolitan Area Transit Authority**, 24 BRBS 133, 136 (1990); **Gilliam v. Addison Crane Co.**, 21 BRBS 91 (1987). The Board has held that 34.4 weeks' wages do constitute "substantially the whole of the year," **Duncan**, **supra**, but 33 weeks is not a

substantial part of the previous year. **Lozupone**, **supra**. Claimant worked for the Employer for the 52 weeks prior to his injury.

Therefore Section 10(a) is applicable.

The parties have stipulated, and the record reflects, that Decedent's average weekly wage as of the date of injury was $1,894.23 and that his benefits are subject to the maximum rate of $738.30 as of the date of such injury. (JX 1)

Accordingly, Decedent's estate is entitled to an award of permanent total disability benefits, at the rate of $738.30, commencing on January 24, 1994, and such benefits shall continue through his death on February 3, 1996.

Death Benefits and Funeral Expenses Under Section 9

Pursuant to the 1984 Amendments to the Act, Section 9 provides Death Benefits to certain survivors and dependents if a work-related injury causes an employee's death. This provision applies with respect to any death occurring after the enactment date of the Amendments, September 28, 1984. 98 Stat. 1655. The provision that Death Benefits are payable only for deaths due to employment injuries is the same as in effect prior to the 1972 Amendments. The carrier at risk at the time of decedent's injury, not at the time of death, is responsible for payment of Death Benefits. **Spence v. Terminal Shipping Co.**, 7 BRBS 128 (1977), **aff'd sub nom. Pennsylvania National Mutual Casualty Insurance Co. v. Spence**, 591 F.2d 985, 9 BRBS 714 (4th Cir. 1979), **cert. denied**, 444 U.S. 963 (1975); **Marshall v. Looney's Sheet Metal Shop**, 10 BRBS 728 (1978), **aff'd sub nom. Travelers Insurance Co. v. Marshall**, 634 F.2d 843, 12 BRBS 922 (5th Cir. 1981).

A separate Section 9 claim must be filed in order to receive benefits under Section 9. **Almeida v. General Dynamics Corp.**, 12 BRBS 901 (1980). This Section 9 claim must comply with Section 13. **See Wilson v. Vecco Concrete Construction Co.**, 16 BRBS 22 (1983); **Stark v. Bethlehem Steel Corp.**, 6 BRBS 600 (1977). Section 9(a) provides for reasonable funeral expenses not exceeding $3,000. 33 U.S.C.A. §909(a) (West 1986). Prior to the 1984 Amendments, this amount was $1,000. This subsection contemplates that payment is to be made to the person or business providing funeral services or as reimbursement for payment for such services, and payment is limited to the actual expenses incurred up to $3,000. Claimant is entitled to appropriate interest on funeral benefits untimely paid. **Adams v. Newport News Shipbuilding and Dry Dock Company**, 22 BRBS 78, 84 (1989).

Section 9(b) which provides the formula for computing Death Benefits for surviving spouses and children of Decedents must be read in conjunction with Section 9(e) which provides minimum

benefits. **Dunn v. Equitable Equipment Co.**, 8 BRBS 18 (1978); **Lombardo v. Moore-McCormack Lines, Inc.**, 6 BRBS 361 (1977); **Gray v. Ferrary Marine Repairs**, 5 BRBS 532 (1977).

Section 9(e), as amended in 1984, provides a maximum and minimum death benefit level. Prior to the 1972 Amendments, Section 9(e) provided that in computing Death Benefits, the average weekly wage of Decedent could not be greater than $105 nor less than $27, but total weekly compensation could not exceed Decedent's weekly wages. Under the 1972 Amendments, Section 9(e) provided that in computing Death Benefits, Decedent's average weekly wage shall not be less than the National Average Weekly Wage under Section 6(b), but that the weekly death benefits shall not exceed decedent's actual average weekly wage. **See Dennis v. Detroit Harbor Terminals**, 18 BRBS 250 (1986), **aff'd sub nom. Director, OWCP v. Detroit Harbor Terminals, Inc.**, 850 F.2d 283 21 BRBS 85 (CRT) (6th Cir. 1988); **Dunn, supra**; **Lombardo, supra**; **Gray, supra**.

In **Director, OWCP v. Rasmussen**, 440 U.S. 29, 9 BRBS 954 (1979), **aff'g** 567 F.2d 1385, 7 BRBS 403 (9th Cir. 1978), **aff'g sub nom. Rasmussen v. GEO Control, Inc.**, 1 BRBS 378 (1975), the Supreme Court held that the maximum benefit level of Section 6(b)(1) did not apply to Death Benefits, as the deletion of a maximum level in the 1972 Amendment was not inadvertent. The Court affirmed an award of $532 per week, two-thirds of the employee's $798 average weekly wage.

However, the 1984 amendments have reinstated that maximum limitation and Section 9(e) currently provides that average weekly wage shall not be less than the National Average Weekly Wage, but benefits may not exceed the lesser of the average weekly wage of Decedent or the benefits under Section 6(b)(1).

In view of these well-settled principles of law, I find and conclude that Claimant, as the surviving Widow of Decedent, is entitled to an award of Death Benefits, commencing on February 4, 1996, the day after her husband's death, based upon the Decedent's average weekly wage $1,894.23, pursuant to Section 6(b), as I find and conclude that Decedent's death resulted from a combination of his work-related pulmonary asbestosis and his COPD. Thus, I find and conclude that Decedent's death resulted from and was related to his work-related injury for which his estate will be receiving permanent total diability benefits from January 24, 1994 until his death on February 3, 1996.

As noted above, the parties have stipulated that the "base widow's compensation rate is $782.44, the maximum rate on February 4, 1996." (JX 1) Accordingly, Death Benefits to Claimant shall be based upon such base rate.

Interest

Although not specifically authorized in the Act, it has been accepted practice that interest at the rate of six (6) percent per annum is assessed on all past due compensation payments. **Avallone v. Todd Shipyards Corp.**, 10 BRBS 724 (1978). The Benefits Review Board and the Federal Courts have previously upheld interest awards on past due benefits to ensure that the employee receives the full amount of compensation due. **Watkins v. Newport News Shipbuilding & Dry Dock Co.**, 8 BRBS 556 (1978), **aff'd in pertinent part** and **rev'd on other grounds sub nom. Newport News v. Director, OWCP**, 594 F.2d 986 (4th Cir. 1979); **Santos v. General Dynamics Corp.**, 22 BRBS 226 (1989); **Adams v. Newport News Shipbuilding**, 22 BRBS 78 (1989); **Smith v. Ingalls Shipbuilding**, 22 BRBS 26, 50 (1989); **Caudill v. Sea Tac Alaska Shipbuilding**, 22 BRBS 10 (1988); **Perry v. Carolina Shipping**, 20 BRBS 90 (1987); **Hoey v. General Dynamics Corp.**, 17 BRBS 229 (1985). The Board concluded that inflationary trends in our economy have rendered a fixed six percent rate no longer appropriate to further the purpose of making claimant whole, and held that ". . . the fixed six percent rate should be replaced by the rate employed by the United States District Courts under 28 U.S.C. §1961 (1982). This rate is periodically changed to reflect the yield on United States Treasury Bills . . . ." **Grant v. Portland Stevedoring Company**, 16 BRBS 267, 270 (1984), **modified on reconsideration**, 17 BRBS 20 (1985). Section 2(m) of Pub. L. 97-258 provided that the above provision would become effective October 1, 1982. This Order incorporates by reference this statute and provides for its specific administrative application by the District Director. The appropriate rate shall be determined as of the filing date of this Decision and Order with the District Director.

Medical Expenses

An Employer found liable for the payment of compensation is, pursuant to Section 7(a) of the Act, responsible for those medical expenses reasonably and necessarily incurred as a result of a work-related injury. **Perez v. Sea-Land Services, Inc.**, 8 BRBS 130 (1978). The test is whether or not the treatment is recognized as appropriate by the medical profession for the care and treatment of the injury. **Colburn v. General Dynamics Corp.**, 21 BRBS 219, 22 (1988); **Barbour v. Woodward & Lothrop, Inc.**, 16 BRBS 300 (1984). Entitlement to medical services is never time-barred where a disability is related to a compensable injury. **Addison v. Ryan-Walsh Stevedoring Company**, 22 BRBS 32, 36 (1989); **Mayfield v. Atlantic & Gulf Stevedores**, 16 BRBS 228 (1984); **Dean v. Marine Terminals Corp.**, 7 BRBS 234 (1977). Furthermore, an employee's right to select his own physician, pursuant to Section 7(b), is well settled. **Bulone v. Universal Terminal and Stevedore Corp.**, 8 BRBS 515 (1978). Claimant is also entitled to reimbursement for reasonable travel expenses in seeking medical care and treatment for his work-related injury. **Tough v. General Dynamics**

Corporation, 22 BRBS 356 (1989); **Gilliam v. The Western Union Telegraph Co.**, 8 BRBS 278 (1978).

In **Shahady v. Atlas Tile & Marble**, 13 BRBS 1007 (1981), **rev'd on other grounds**, 682 F.2d 968 (D.C. Cir. 1982), **cert. denied**, 459 U.S. 1146, 103 S.Ct. 786 (1983), the Benefits Review Board held that a claimant's entitlement to an initial free choice of a physician under Section 7(b) does not negate the requirement under Section 7(d) that claimant obtain employer's authorization prior to obtaining medical services. **Banks v. Bath Iron Works Corp.**, 22 BRBS 301, 307, 308 (1989); **Jackson v. Ingalls Shipbuilding Division, Litton Systems, Inc.**, 15 BRBS 299 (1983); **Beynum v. Washington Metropolitan Area Transit Authority**, 14 BRBS 956 (1982). However, where a claimant has been refused treatment by the employer, he need only establish that the treatment he subsequently procures on his own initiative was necessary in order to be entitled to such treatment at the employer's expense. **Atlantic & Gulf Stevedores, Inc. v. Neuman**, 440 F.2d 908 (5th Cir. 1971); **Matthews v. Jeffboat, Inc.**, 18 BRBS at 189 (1986).

An employer's physician's determination that Claimant is fully recovered is tantamount to a refusal to provide treatment. **Slattery Associates, Inc. v. Lloyd**, 725 F.2d 780 (D.C. Cir. 1984); **Walker v. AAF Exchange Service**, 5 BRBS 500 (1977). All necessary medical expenses subsequent to employer's refusal to authorize needed care, including surgical costs and the physician's fee, are recoverable. **Roger's Terminal and Shipping Corporation v. Director, OWCP**, 784 F.2d 687 (5th Cir. 1986); **Anderson v. Todd Shipyards Corp.**, 22 BRBS 20 (1989); **Ballesteros v. Willamette Western Corp.**, 20 BRBS 184 (1988).

Section 7(d) requires that an attending physician file the appropriate report within ten days of the examination. Unless such failure is excused by the fact-finder for good cause shown in accordance with Section 7(d), claimant may not recover medical costs incurred. **Betz v. Arthur Snowden Company**, 14 BRBS 805 (1981). **See also** 20 C.F.R. §702.422. However, the employer must demonstrate actual prejudice by late delivery of the physician's report. **Roger's Terminal**, **supra**.

On the basis of the totality of the record, I find and conclude that Claimant has shown good cause, pursuant to Section 7(d). Claimant advised the Employer of his work-related injury in a timely manner and requested appropriate medical care and treatment. However, the Employer did not accept the claim and did not authorize such medical care. Thus, any failure by Claimant to file timely the physician's report is excused for good cause as a futile act and in the interests of justice as the Employer refused to accept the claim.

Accordingly, in view of the foregoing, the Employer shall pay for such reasonable and necessary medical care and treatment relating to Decedent's asbestosis and COPD, commencing on October 12, 1993, and such expenses shall be subject to the provisions of Section 7 of the Act.

Section 14(e)

Claimant is not entitled to an award of additional compensation, pursuant to the provisions of Section 14(e), as the Employer timely controverted the entitlement to benefits by Decedent and Claimant. **Ramos v. Universal Dredging Corporation**, 15 BRBS 140, 145 (1982); **Garner v. Olin Corp.**, 11 BRBS 502, 506 (1979).

Attorney's Fee

Claimant's attorney, having successfully prosecuted this matter, is entitled to a fee assessed against the Employer as a self-insurer. Claimant's attorney filed a fee application on August 30, 2002 (CX 6), concerning services rendered and costs incurred in representing Claimant between October 27, 2001 and July 30, 2002. Attorney Melissa M. Olson seeks a fee of $3,442.74 (including expenses) based on 14.50 hours of attorney time and 2 hours of paralegal time.

In accordance with established practice, I will consider only those services rendered and costs incurred on and after October 27, 2001. Services rendered prior to this date should be submitted to the District Director for her consideration.

In light of the nature and extent of the excellent legal services rendered to Claimant by her attorney, the amount of compensation obtained for Claimant and the Employer's lack of comments on the requested fee, I find a legal fee of $3,442.74 (including expenses of $53.74) is reasonable and in accordance with the criteria provided in the Act and regulations, 20 C.F.R. §702.132, and is hereby approved. The expenses are approved as reasonable and necessary litigation expenses.

ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law and upon the entire record, I issue the following compensation order. The specific dollar computations of the compensation award shall be administratively performed by the District Director.

It is therefore **ORDERED** that:

1. The Employer as a self-insurer, commencing on January 24,

1994 and continuing thereafter until February 3, 1996, shall pay to the Claimant, as executrix of Dececent's estate, compensation benefits for his permanent total disability, plus the applicable annual adjustments provided in Section 10 of the Act, based upon an average weekly wage of $1,894.03. Such compensation to be computed in accordance with Section 8(a) of the Act is subject to the maximum compensation rate of $738.30.

2. The Employer shall pay Decedent's widow, Rheta De Martino, ("Claimant"), Death Benefits from February 4, 1996, in accordance with Section 9 of the Act, and such benefits shall continue for as long as she is eligible therefor. Such benefits shall be based upon the base rate of $782.44, the maximum rate in effect at the time of death.

3. The Employer shall reimburse or pay Claimant reasonable funeral expenses of $3,000.00, pursuant to Section 9(a) of the Act.

4. Interest shall be paid by the Employer on all accrued benefits at the T-bill rate applicable under 28 U.S.C. §1961 (1982), computed from the date each payment was originally due until paid. The appropriate rate shall be determined as of the filing date of this Decision and Order with the District Director. Interest shall also be paid on the funeral benefits untimely paid by the Employer.

5. The Employer shall receive credit for all amounts of compensation previously paid to the Decedent and Claimant as a result of his October 12, 1993 injury.

6. The Employer shall furnish such reasonable, appropriate and necessary medical care and treatment as the Claimant's work-related injury referenced herein may require, even after the time period specified in the first Order provision above, subject to the provisions of Section 7 of the Act, commencing on October 12, 1993.

7. The Employer shall pay to Claimant's attorney, Melissa Olson, the sum of $3,442.74 (including expenses) as a reasonable fee for representing Claimant herein between October 27, 2001 and July 30, 2002.

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DAVID W. DI NARDI
District Chief Judge

Boston, Massachusetts
DWD:dsr